Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING: B. WING MHL036-091 11/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 TOT DELLINGER ROAD **VOCA - DELLINGER** CHERRYVILLE, NC 28021 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 A complaint survey was completed on November 12, 2019. The complaint was substantiated (Intake #NC00157924). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults Whose Primary Diagnosis is a Developmental Disability. V 109 27G .0203 Privileging/Training Professionals V 109 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate DHSR - Mental Health professionals shall demonstrate knowledge, skills and abilities required by the population served. DEC 0 3 2019 (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate Lic. & Cert. Section professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIED REPRESENTATIVE'S SIGNATURE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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V 109	Continued From page	1	V 109			
	plan upon hiring each (g) The associate pro	ied professional with the the period of time as				
	This Rule is not met at Based on interview and audited qualified profes Professional #1 and Professional #2) failed knowledge, skills and a population served. The	d record review, 2 of 2 ssionals (Qualified rogram Manager/Qualified to demonstrate the abilities required by the				
	Review on 11/7/19 of the #1's record revealed: -Hire date 4/12/18.	he Qualified Professional				
	Review on 11/7/19 of the Manager/Qualified Propreyealed: -Hire date of 4/23/18.					
	Review on 11/7/19 of a report and supporting of #1 and Former Staff #4 -Incident report dated 1 allegation of abuse rep	locuments involving Client revealed: 0/23/19 regarding an				
	revealed:	in their respective				

PRINTED: 11/18/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL036-091 11/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 TOT DELLINGER ROAD **VOCA - DELLINGER** CHERRYVILLE, NC 28021 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 109 Continued From page 2 V 109 -The clients spent some afternoons into early evenings at a sister facility where they received medications and meals. They waited until 8pm before they were picked up and returned home due to lack of staffing. Interview on 11/7/19 with the Qualified Professional #1 revealed: -Did not disclose the 10/16/19 allegation of abuse involving Client #1 and Former Staff #4 as well as the administrative suspension of Former Staff #4 during the Division of Health Service Regulation (DHSR) annual survey on 10/21/19; -Lack of disclosure of the 10/16/19 allegation of abuse was a result of not specifically being asked about the issues: -Clients from the facility were taken to a sister facility in a neighboring county because there was no staff available to work at the facility; -Clients were given medication and meals at the sister facility on days there was no staff available to work at the facility; -Did not know the clients were not allowed to stay at the sister facility when no staff were available to work at the facility; -Will ensure staff are available for all shifts, ensuring the facility operates 24 hours per day. Interview on 11/7/19 with the Program Manager/Qualified Professional #2 revealed: -Completed the incident report involving the 10/16/19 allegation of abuse reported by Client #1

IRIS);

against Former Staff #4 through North Carolina Incident Response Improvement System (NC

-Will make sure all incident reports are completed

-Did not disclose the 10/16/19 allegation of abuse

-Was his oversight that the Level III incident

report was filed late in NC IRIS:

in a timely manner in the future;

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
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V 109	Continued From page	3	V 109				
	reported by Client #1 a well as the administrat Staff #4 during the Div Regulation (DHSR) ar -Lack of disclosure to allegation of abuse wa -All staff will receive achow to respond to alle client rights in an upcomid-November, 2019. completed by another -Will ensure staff are a ensuring the facility op Interview on 11/12/19 arevealed: -Will provide additional regarding abuse and c -Will meet with the clie client rights and encour forward should they be violated; -Failure to disclose the	against Former Staff #4 as tive suspension of Former vision of Health Service nual survey on 10/21/19; DHSR of the 10/16/19 as not intentional; dditional training regarding gations of abuse as well as oming training to be held in The training will be administrator; available for all shifts, berates 24 hours per day.  With the Executive Director I training to all staff lient rights; nts to discuss abuse and					
V 110	27G .0204 Training/Su Paraprofessionals	pervision	V 110				
	SUPERVISION OF PA (a) There shall be no p paraprofessionals.	orivileging requirements for shall be supervised by an or by a qualified ed in Rule .0104 of this shall demonstrate					

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY	
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V 110	Continued From page	4	V 110				
	population served. (d) At such time as a employment system is then qualified professi professionals shall det (e) Competence shall exhibiting core skills in (1) technical knowled (2) cultural awarenes (3) analytical skills; (4) decision-making; (5) interpersonal skills (6) communication skills (7) clinical skills. (f) The governing bod develop and implement	competency-based s established by rulemaking, onals and associate monstrate competence. be demonstrated by including: lge; s; s; sills; and y for each facility shall it policies and procedures individualized supervision					
	This Rule is not met as evidenced by: Based on interview and record review, 1 of 2 audited paraprofessionals (House Manager) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:						
	Review on 11/7/19 of the record revealed: -Hire date 2/1/14.	ne House Manager 's					
	Review on 11/7/19 of a report and supporting of #1 and Former Staff #4 -Incident report dated 1	locuments involving Client revealed:					

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V 110	Continued From page	5	V 110			
	allegation of abuse or	10/16/19.				
	Interview on 11/7/19 virevealed: -Former Staff #4 had it using a raised tone of clients spend morning bedrooms until it was: -The clients spent some evenings at a sister famedications and meal before they were picked due to lack of staffing.  Interview on 11/7/19 wirevealed: -Did not disclose the 1 involving Client #1 and the administrative sust during the Division of It (DHSR) annual survey-Lack of disclosure of tabuse was because shacessary to do so; -Clients from the facility in a neighboring no staff available to work at the facility; -Did not know the clien at the sister facility whe to work at the facility; -Will ensure staff are an ensuring the facility opel.	with Clients #1, #2, and #3  Deen mean to the clients by voice and making the s in their respective time to leave the facility; ne afternoons into early cility where they received s. They waited until 8pm and up and returned home  O/16/19 allegation of abuse of Former Staff #4 as well as pension of Former Staff #4 as well as pension of Former Staff #4 as well as pension of Former Staff #4 dealth Service Regulation of no 10/21/19; the 10/16/19 allegation of the did not realize it was been was at the facility; adication and meals at the pere was no staff available the war no staff were available to stay the staff and shifts, the pere staff and shifts, the pere staff and shifts, the program to the facility of the pere staff and shifts, the program to the facility of the pere staff and shifts, the program to the clients by the pere staff and shifts, the program to the clients by the pere staff and shifts, the program to the clients by the pere staff and shifts, the program to the clients by the pere staff and shifts, the program to the clients by the pere staff and shifts, the program to the clients by the pere staff and shifts, the program to the clients by the pere staff and shifts, the program to the clients by the pere staff and shifts and shift				

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V 289	27G .5601 Supervised	Living - Scope	V 289			
	provides residential ser home environment whe these services is the ca rehabilitation of individual illness, a developmenta or a substance abuse of supervision when in the (b) A supervised living the facility serves either	uals who have a mental al disability or disabilities, disorder, and who require a residence. facility shall be licensed if				

	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
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V 28	9 Continued From page	7	V 289			
V 28	(2) two or more Minor and adult clients same facility. (c) Each supervised li licensed to serve a special designated below: (1) "A" designated serves adults whose provided illness but may also has a serves minors whose provided ideagnoses; (3) "C" designation diagnoses; (3) "C" designation diagnoses; (4) "D" designation diagnoses; (4) "D" designation diagnoses; (5) "E" designation serves minors whose provided ideagnoses; (5) "E" designation serves adults whose provided ideagnoses; (6) "F" designation serves adults whose provided ideagnoses; (6) "F" designation serves adults whose provider esidence, which there adult clients whose mental illness but may disabilities, or three adult clients whose primary of developmental disabilition of the disabilities who ling family provides the servex exempt from the following country (2) (1), (2), (3), (4), (4), (B), (E), (F), (G), (H); (18) and (b); 10A NCACO	adult clients. Is shall not reside in the Inving facility shall be ecific population as It ion means a facility which rimary diagnosis is mental ave other diagnoses; It ion means a facility which romany diagnosis is a Ity but may also have other It ion means a facility which rimary diagnosis is a Ity but may also have other It ion means a facility which rimary diagnosis is It indency but may also have Ion means a facility which rimary diagnosis is Indency but may also have Ion means a facility in a Ith serves no more than Is primary diagnoses is I also have other I till clients or three minor I diagnoses is I ies but may also have I we with a family and the I wice. This facility shall be Ing rules: 10A NCAC 27G	V 289			

PRINTED: 11/18/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED B. WING MHL036-091 11/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 TOT DELLINGER ROAD **VOCA - DELLINGER** CHERRYVILLE, NC 28021 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 289 | Continued From page 8 V 289 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide services 24 hours per day affecting 3 of 3 clients (Clients #1, #2, and #3). The findings are: Review on 11/7/19 of Client #1's record revealed: -Admitted 4/1/1995; -Diagnosed with Moderate Intellectual Developmental Disability, Chronic Schizophrenia, Behavior Disorder, Fibrocystic Breast Disease, Hypothyroidism, History of Hiatal Hernia. Review on 11/7/19 of Client #2's record revealed: -Admitted 1/23/13; -Diagnosed with Moderate Intellectual Developmental Disability, Major Depressive Disorder, Infantile Cerebral Palsy, Epilepsy. Review on 11/7/19 of Client #3's record revealed: -Admitted 10/1/15; -Diagnosed with Moderate Intellectual Developmental Disability, Generalized Anxiety

Disorder, Hypothyroidism, Allergic Rhinitis, Gastroesophageal Reflux Disorder.

Interview on 11/7/19 with Client #1 revealed: -A female staff member from a sister facility

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V 289	Continued From page	9	V 289				
	picked her up after wo -Did not know the nam member who picked h -Was taken by the fem sister facility; -Took medication at th -Did not know if she ha facility; -A staff member from t would pick her up at th been done in the past; -Not sure why or how a sister facility; -Liked going to the sist  Interview on 11/7/19 w -A female staff membe picked him up after bin -The female staff mem member in the van with and two male clients fr -The clients were taker only the one female sta -Did not take any medi because he is not sche medications until bedtir -The female staff mem picked up the 3 clients there was no staff mem the facility; -Was taken to the sister and stayed at the sister staff member from the fi pick up; -Had gone to the sister at the facility approxima month of October, 2015	ork on 11/7/19; ne of the female staff er up after work; nale staff member to a sister facility; ad eaten dinner at the sister the facility where she lives he sister facility, as had often she was taken to the ser facility.  Which client #2 revealed: It from a sister facility go on 11/7/19; ber was the only staff of Clients #1, #2, and #3 om the sister facility; In to the sister facility with aff member; cations at the sister facility eduled to take any me; ber from the sister facility because of facility a few weeks ago of facility until 8pm when a facility was available to facility due to lack of staff ately 2 times during the en addition to 11/7/19;	V 289				
	month of October, 2019	9 in addition to 11/7/19; or facility when there was					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING: COMPLETED  MHL036-091  B. WNG 11/12/20  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  VOCA - DELLINGER  310 TOT DELLINGER ROAD  CHERRYVILLE, NC 28021  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
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CHERRYVILLE, NC 28021	
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V 289 Continued From page 10 V 289	
Interview on 11/7/19 with Client #3 revealed:  -A female staff member from a sister facility picked her up on 11/7/19; -The female staff member was the only staff member in the van with Clients #1, #2, and #3 and two male clients from the sister facilityThe clients were taken to the sister facility with only the one female staff member; -Took her 4pm scheduled medications at the sister facilityWas taken to the sister facility because there was no staff available to work at the facility; -Was taken to the sister facility a few weeks ago and stayed at the sister facility was available to pick up; -Went to the sister facility "a lot" and waited for staff to come to pick up Clients #1, #2, and #3 after reporting to work at 8pm; -Had dinner and took medications at the sister facility when there was no staff at the facility; -Liked going to the sister facility.  Interviews on 11/7/19 with the House Manager and the Qualified Professional #1 revealed: -Clients from the facility were taken to a sister facility in a neighboring county because there was no staff available to work at the facility; -Clients were given medication and meals at the sister facility on days there was no staff available to work at the facility; -Did not know the clients were not allowed to stay at the sister facility when no staff were available to work at the facility; -Vill ensure staff are available for all shifts, ensuring the facility operates 24 hours per day.  Interview on 11/7/19 with the Program Manager/Qualified Professional #2 revealed:	

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
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V 289	Continued From page	11	V 289				
	-Will ensure staff are a						
	ensuring the facility of	perates 24 hours per day.					
	Interview on 11/12/19	with the Qualified					
		ram Manager/Qualified					
		Executive Director revealed:					
		operates 24 hours daily.					
	,						
V 367	27G .0604 Incident Re	eporting Requirements	V 367				
	10A NCAC 27G .0604	INCIDENT					
	REPORTING REQUIR						
	CATEGORY A AND B	PROVIDERS					
	(a) Category A and B	providers shall report all					
		pt deaths, that occur during					
	the provision of billable						
		oviders premises or level III					
		eaths involving the clients					
		endered any service within					
	90 days prior to the incresponsible for the cate						
	services are provided v						
		incident. The report shall					
	be submitted on a form						
		may be submitted via mail,					
	in person, facsimile or						
	means. The report sha	all include the following					
	information:					1	
		vider contact and				1	
	identification informatio					1	
	<ul><li>(2) client identific</li><li>(3) type of incide</li></ul>	cation information;				- 1	
	(4) type of incide (4) description of					1	
		effort to determine the				- 1	
	cause of the incident; a	A CONTRACTOR OF THE CONTRACTOR				- 1	
		als or authorities notified				- 1	
1	or responding.					I	
		providers shall explain any					
		nformation. The provider				i i	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367 Continued From page 12 V 367	
shall submit an updated report to all required report recipients by the end of the next business day whenever:  (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable.  (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .3300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterfy to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident;	

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		MHL036-091	B. WING		11/	12/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	TATE, ZIP CODE		
VOCA D	ELLINGER	310 TOT D	ELLINGER R	OAD		
VOCA - D	PELLINGER	CHERRYV	ILLE, NC 280	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 367	(3) searches of (4) seizures of (5) the total nun incidents that occurred (6) a statement been no reportable indincidents have occurred meet any of the criteria (a) and (d) of this Rule through (4) of this Parallel through (4) of this Parallel to report all Leve Local Management Enbecoming aware of the are:  Review on 11/7/19 of C-Admitted 4/1/1995; -Diagnosed with Mode Developmental Disabil Behavior Disorder, Fibhypothyroidism, Histor Review on 11/7/19 of a report and supporting of #1 and Former Staff #4-Incident report dated allegation of abuse on Interview on 11/7/19 with Mental Health (DMH) A North Carolina Incident	a client or his living area; client property or property in ient; nber of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that a as set forth in Paragraphs and Subparagraphs (1) agraph.  Is evidenced by: d record review, the facility el III incident reports to the stity within 72 hours of exincidents. The findings  Client #1's record revealed:  In Internal Investigation documents involving Client arevealed:  In Internal Investigation and Investigation documents involving Client arevealed:  In Internal Investigation and	V 367			
	System (NC IRIS) reve -The incident report inv					

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL036-091	B. WING		11/	12/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
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		CHERRYV	ILLE, NC 280	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	Continued From page	14	V 367			
V 367	Former Staff #4 regard on 10/16/19 was not of complete manner;  -The incident report was reachly staff should on Administrator as soon necessary corrections the 10/16/19 allegation. Interview on 11/7/19 was professional #1 reveal. The incident report of 10/16/19 allegation of Former Staff #4 was on Manager/Qualified Progressional #1 reveal. The incident report was linearly was manager/Qualified Progressional #1 reveal. Contacted the DMH At to update the information of against Former Staff #1 Incident Response Implification of against Former Staff #1 Incident Response Implification of the Incident Response Implification of Incident Response Implication of Incident Response Incident Response Incident Response Incident Response Incident Response Incident Re	ding the allegation of abuse completed in a timely or a as filed several days late; ontact the DMH as possible to make within NC IRIS regarding in of abuse.  With the Qualified led:  In the Program lessional #2 revealed:  In the Program lessional #2 reveal	V 367			
	in a timely manner in the	ne future.				
V 513	27E .0101 Client Right Alternative	s - Least Restictive	V 513			
	10A NCAC 27E .0101 ALTERNATIVE	LEAST RESTRICTIVE				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING	1			
		MHL036-091	B. WING		11/	12/2019	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE ZIR CODE		12/2010	
			DELLINGER R				
VOCA - D	ELLINGER		ILLE, NC 280				
(X4) ID	SLIMMADY STA	ATEMENT OF DEFICIENCIES					
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V 513	Continued From page	15	V 513				
	(a) Each facility shall that promote a safe ar These include: (1) using the lea appropriate settings at (2) promoting conskills that are alternatively self or others; (3) providing chameaningful to the client (4) sharing of continuous the client/legally responsible to the client (4) sharing of continuous the client (5) The use of a restription of the client (6) The use of a restription of the client (7) and the client (8) the client (9) the client (10) the client (11) using the interval time (12) using the interval time (13) using the interval time (14) using the interval time (15) using the interval time (16) using the interval time (17) using the interval time (18) using time (18)	provide services/supports and respectful environment.  ast restrictive and most and methods; oping and engagement eves to injurious behavior to soices of activities and served/supported; and control over decisions with ensible person and staff. Cive intervention or reduce a behavior shall end by actions designed to seet during and after the					
	failed to promote a safe environment affecting a (Clients #1, #2, and #3 Review on 11/7/19 of C -Admitted 4/1/1995; -Diagnosed with Moder Developmental Disabili Behavior Disorder, Fibr Hypothyroidism, History	d record review, the facility e and respectul affecting 3 of 3 clients ). The findings are: Client #1's record revealed: rate Intellectual ty, Chronic Schizophrenia, rocystic Breast Disease,					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY	
7.1.61.6.1	A. BUILDING:		COM	PLETED			
		MHL036-091	B. WING			/12/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
VOCA - I	DELLINGER		DELLINGER RO				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 513	-Diagnosed with Mode Developmental Disabi Disorder, Infantile Cer Review on 11/7/19 of -Admitted 10/1/15; -Diagnosed with Mode Developmental Disabi Disorder, Hypothyroid Gastroesophageal Re Review of Former Stati-Hire date 4/12/18; -Employed as Direct S-Job description signerinteracts frequently a served" -Last worked 10/15/19 Review on 11/7/19 of a report and supporting #1 and Former Staff #4-Incident report dated allegation of abuse on -Internal investigation of findings against Former "for using inappropri with the clients"  Interview on 11/7/19 wi-Vas sent to his room in received his medication -Did not know why he wi-Went to his room each medications because his do;	erate Intellectual lity, Major Depressive rebral Palsy, Epilepsy.  Client #3's record revealed:  erate Intellectual lity, Generalized Anxiety ism, Allergic Rhinitis, flux Disorder.  If #4's record revealed:  Support Professional; d 4/12/18 revealed: " and positively with persons  an Internal Investigation documents involving Client 4 revealed: 10/23/19 regarding an 10/16/19; revealed substantiated er Staff #4 for verbal abuse ate verbal communications  ith Client #1 revealed: by Former Staff #4 after he as each morning; was sent to his room;	V 513				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		MHL036-091	B. WING		11/	12/2019	
NAME OF PROVIDED OF A PARTY.			RESS, CITY, ST	ATE, ZIP CODE	11/	12/2019	
VOCA - D	ELLINGER		ELLINGER R				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
	-Client #2 never told a #4 yelling at Clients # -Denied Former Staff toward clients or called Interview on 11/7/19 w -Was sent to her bedro- Former Staff #4 would bedroom until 8am; -Client #3 wanted to so watch television in the Former Staff #4 would come out of the bedro- "Don't hurt my feeling longer worked at the fa- Denied Former Staff #4 toward clients or called Interview on 11/8/19 w revealed: -Worked at the facility years as a Direct Supp- Job responsibilities indovernight and getting to the facility for the day; -Last day worked at the -Worked third shift; -Denied yelling at clien -Denied restricting clien mornings.  Interview on 11/7/19 wi revealed: -Former Staff #4 was s due to substantiated ve -Reviewed abuse and of 10/30/19 staff meeting, the meeting.	inyone about Former Staff 1, #2, and #3; #4 ever used foul language d clients derogatory names.  ith Client #3 revealed: born by Former Staff #4; d not let Client #3 out of her it in the living room and mornings; d tell clients they could not borns until 8am; s" that Former Staff #4 no acility; #4 ever used foul language d clients derogatory names.  ith Former Staff #4  almost one and one-half bort Professional; cluded caring for the clients the clients ready to leave the facility was 10/15/19; tts; tts; tts to their bedrooms in the  th the House Manager eparated from the facility brbal abuse and yelling;	V 513				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	A. BUILDING:		:			
		MHL036-091	B. WING		11/	12/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DESS CITY ST	FATE, ZIP CODE	1 11/	12.2010
	THE		ELLINGER R			
VOCA - D	ELLINGER		LLE, NC 280			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 513	Continued From page	18	V 513			
	#1 and Program Mana #2 revealed: -During the process of completed regarding to abuse by Client #1 agus was discovered clients out of their bedrooms: -Former Staff #4's instremain in their bedroom reflective of the agency-Former Staff #4's vert is not reflective of the tits employees; -Mandatory staff training mid-November, 2019 to abuse.	ager/Qualified Professional  f the internal investigation he 10/16/19 allegation of ainst Former Staff #4, it s were not being allowed in the morning before 8am; ructions for clients to ms until 8am is not				
	revealed: -Will provide additional regarding abuse and ci-Will meet with the client client rights and encour forward should they be violated; -Former Staff #4's actionagency philosophy or provided in the staff was a staff	training to all staff lient rights; nts to discuss abuse and rage clients to come dieve their rights have been ons are not reflective of policy.				
	from further risk or add Accused staff [Former of put on leave for employ investigation. She new internal investigation was Staff #4] was terminate	nager/Qualified 11/8/19 revealed: stely do to correct the order to protect clients itional harm? Staff #4] was immediately /ment pending outcome of er returned to work. An as completed and [Former				

Division of Health Service Regulation

STATE FORM RE1011 If continuation sheet 19 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-091	B. WING		11/	12/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
VOCA - D	ELLINGER		ELLINGER R ILLE, NC 280			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	at staff meeting on 10 Describe your plans to happens. [Additional Program M Professional] will held training on reporting p Neglect and Clients R Manager/Qualified Pro Professional #1, and H group home staff by no Reporting procedures, Client Rights will be a monthly staff meeting.  Clients #1, #2, and #3 but not limited to, Mod Developmental Disabil Major Depressive Diso Anxiety Disorder. For clients using a harsh a during interactions with Former Staff #4 restric bedrooms until 8am. A #4's actions, the facility safe and respectful ma detrimental to the healt Clients #1, #2, and #3. constitutes a Type B ru is not corrected within a penalty of \$200.00 per	danager/Qualified extensive and thorough rocedures, Abuse and ights with [Program of the sessional #2, Qualified douse Manager] and all to later than 11/15/19.  Abuse and Neglect and permanent part of all agendas."  had diagnoses including, erate Intellectual ity, Chronic Schizophrenia, order and Generalized mer Staff #4 yelled at not raised tone of voice in the clients. Furthermore, ted clients to their was not operated in a nner which was th, safety, and welfare of	V 513			

## Community Alternatives-North Carolina

301 10th St. NW Suite B 101 Conover, NC 28613

828.466.6023 fax: 828.466.6025 www.ResCare.com

November 27, 2019

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718 DHSR - Mental Health

DEC 0 3 2019

Lic. & Cert. Section

Re: Plan of Correction -MHL-036-091 VOCA-Tot- Dellinger 310 Tot Dellinger Road Cherryville, NC 28021

On November 12, 2019, a complaint survey was conducted at 310 Tot-Dellinger Road Cherryville, NC 28021 by the Mental Health Licensure and Certification Section of the NC Division of Health Service Regulation. Attached you will find a copy of the deficiencies along with the Plan of Correction.

Please do not hesitate to contact me should you have any questions at 828-466-6023 ext. 225 or <a href="mailto:adolph.gordon@rescare.com">adolph.gordon@rescare.com</a> or <a href="mailto:Mike Penland">Mike Penland</a>, <a href="mailto:Executive Director">Executive Director</a> at 828-466-6023 ext. 221 or <a href="mailto:mpenland@rescare.com">mpenland@rescare.com</a>

Singerely,

Adolph Gordon

Program Manager, CANC-West

## Voca-Dellinger Plan of Correction

V109: Program Manager, QP, Home Supervisor and Group Home staff were trained on Abuse and Neglect as well as Abuse and Neglect Reporting Procedures by ICF Program Manager on 10/15/19. All staff will continue to be in-serviced on Abuse and Neglect as well as Abuse and Neglect Reporting Procedures at monthly staff meetings.

Program Manager and QP were in-serviced on IRIS Reporting (timeliness, correctness and completeness) on 11/25/2019 by Executive Director. Program Manager and/or QP will ensure all future IRIS reports are submitted on time and are correctly and completely filled out upon submission.

V110: Internal investigation was completed by a trained investigator and staff was terminated on 10/29/19 due to verbal abuse allegation being substantiated.

V289: Home Supervisor, QP and Program Manager will immediately ensure there are staff at the facility on all shift to enable the facility to be open to client's living in the home 24 hours a day. Home Supervisor will continuously interview applicants and will offer employment to any applicant that meets eligibility requirements to ensure home will stay staffed at all times.

V367: Program Manager and QP were in-serviced on IRIS Reporting (timeliness, correctness and completeness) on 11/25/2019 by Executive Director. Program Manager and/or QP will ensure all future IRIS reports are submitted on time and are correctly and completely filled out upon submission.

V513: Internal investigation was completed by a trained investigator and staff was terminated on 10/29/19 due to verbal abuse allegation being substantiated.

Program Manager will meet with clients on 11/27/19 to discuss about and clients rights and encourage clients to report if they feel they are being abused or that their rights are being violated. Anytime Program Manager, QP or Home Supervisor is in the home, they will continue to discuss abuse and clients rights with the clients.

QP will develop a written training program for consumers in the home to work on discussing/reporting any issues of abuse/neglect or violation of client's rights when they feel these things are going on in their home. This WTP will go into effect 12/1/19. This WTP will be reviewed monthly as a part of monthly Q notes.